Medicare coverage in a skilled nursing facility

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Sometimes patients no longer need all the services that hospitals provide, but still need daily skilled nursing or rehabilitation services as inpatients. In these cases, the doctor may transfer a patient from the hospital to a skilled nursing facility. Medicare hospital insurance covers post-hospital care in a skilled nursing facility that participates in Medicare.

Participating facilities are staffed and equipped to furnish skilled nursing care, rehabilitation services, and other related health services. They are required to meet certain health, safety, and professional standards, and they must have and adhere to written policies regarding the rights of patients. In some facilities, only certain sections participate in Medicare. If you are not sure whether a facility or part of the facility participates in Medicare, ask someone at the facility or call a social security office.

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When hospital insurance pays

Hospital insurance can help pay for covered services provided by a skilled nursing facility only if *all* of the following five conditions are met: (1) you have been in a hospital at least 3 days in a row (not counting the day of discharge) before your transfer to a participating skilled nursing facility, (2) you are transferred to the skilled nursing facility because you require further care for a condition which was treated in the hospital, (3) you are admitted to a facility within a short time (generally within 14 days) after you leave the hospital, (4) a doctor certifies that you need, and you continue to receive, skilled nursing or skilled rehabilitation services on a daily basis, and (5) the facility's Utilization Review Committee or the Professional Standards Review Organization in the area does not disapprove your stay.

When all five conditions are met, hospital insurance can help pay for your care for up to a maximum of 100 days in each benefit period—but only if you need this kind of care that long.

Hospital insurance pays all of the costs of covered services for the first 20 days and all but $20 per day for up to 80 more days.

If you leave a participating skilled nursing facility and are readmitted within 14 days, you do not have to have a new 3-day stay in the hospital for your care to be covered. If you have some of your 100 days left and you need daily skilled nursing or rehabilitation services for further treatment of a condition treated during your previous stay in the facility, your care can be covered.

When hospital insurance cannot pay

If a doctor places you in a skilled nursing facility when the care you need does not include daily skilled nursing or rehabilitation services or when the kind of care you need could be provided elsewhere, Medicare hospital insurance cannot pay for your care.

Medicare cannot pay for custodial care in a skilled nursing facility or elsewhere. Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or technical training. For example, help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine would be considered custodial care.

The skilled nursing facility's Utilization Review Committee or the Professional Standards Review Organization for the area regularly reviews the care furnished to patients under Medicare. If after a medical review, the doctors on the Utilization Review Committee or the Professional Standards Review Organization find that daily inpatient skilled nursing or rehabilitation services are not medically necessary, Medicare hospital insurance cannot pay for that part of the skilled nursing facility stay that is unnecessary.

What hospital insurance covers

Covered services during a skilled nursing facility stay include the costs of:

- Semiprivate room (2-4 beds) and all meals including special diets;
- Regular nursing services;
- Rehabilitation services such as physical, occupational, and speech therapy;
- Drugs furnished by the skilled nursing facility while you are an inpatient;
- Medical supplies such as splints and casts;
- Use of appliances and equipment furnished by the facility such as a wheelchair, crutches, or braces.

Hospital insurance pays the participating skilled nursing facility for all covered services provided to you. The skilled nursing facility cannot charge you for any services that Medicare will cover.

What hospital insurance does not cover

Hospital insurance does not cover:

- Personal comfort or convenience items such as a telephone, radio, or television furnished at your request;
- Private duty nurses;
- Any extra charge for a private room, unless ordered for medical reasons by your doctor;
- The first 3 pints of blood you receive in a benefit period. (You do not have to pay for the first 3 pints if you have them replaced through a blood plan membership or have someone donate blood for you.)

How medical insurance helps

During a stay in a skilled nursing facility, medical insurance can help pay some of your expenses that are not covered by hospital insurance. Medical insurance covers your doctor's visits. If the skilled nursing facility does not provide laboratory tests, lab tests your doctor orders for you can be paid when they are done by an independent laboratory certified by Medicare, or they can be covered as part of your doctor's services when they are included on his or her bill.

After you have $60 in "reasonable charges" for covered services (the $60 annual medical insurance deductible), medical insurance pays 80 percent of the reasonable charges for all additional covered services during the rest of the calendar year.

For more information

More detailed information about Medicare can be found in *Your Medicare Handbook.* If you don't have a handbook, you can get one at any social security office. The people there can also answer questions you may have about Medicare or refer you to the appropriate Medicare claims organization in your area.

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